ABDOMINAL HYSTERECTOMY

FOR

INTRALIGAMENTOUS FIBROID TUMOR; ENUCLEATION; VAGINAL FIXATION OF THE STUMP.

Clinical Lecture delivered at St. Luke's Hospital, Chicago.

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[REPRINTED FROM INTERNATIONAL CLINICS, OCTOBER, 1891.]

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GENTLEMEN,—Some points about the case we have to-day are obscure, and it will be necessary to make an examination to determine just what the trouble is, and what we shall do. At two office examinations I diagnosticated uterine fibroid developed in the pelvic connective tissue. To-day the mass felt very much like a subperitoneal hæmatoma. The history is indefinite. We have no history of extra-uterine pregnancy, nor of an acute attack to cause hæmatoma, although there has been a suppressed menstruation. Nor has there been that interference with the action of the bowels which often accompanies the latter, particularly in the beginning. Lately her trouble has been increasing, and she has experienced much local distress, general weakness, and loss of appetite. There is no menorrhagia. The tumor fills the pelvis almost as if moulded in it, and extends above the pubes. The question is, Shall we make an abdominal section or shall we puncture through the vagina? If we make an abdominal section and find a hæmatoma, we can clean it out very thoroughly and possibly stitch the edges of the capsule to the abdominal wall. If we make an incision or puncture through the vagina and find a fibroid, we may thus complicate our subsequent abdominal section. On the other hand, if we find a hæmatoma, we can scoop out the blood-clots and drain from below without entering the peritoneal cavity.

The patient is now thoroughly relaxed by the ether, and we shall make our final examination. She is a married woman, Nora M., forty-

four years old, and has never been pregnant. On inspection the abdomen appears somewhat full. A fibroid of this size nearly always causes the greatest prominence over the symphysis, at or near the median line. This tumor evidently does not do that. There is an indefinite feeling of hardness in the median line, but there is slight resonance over the pubes, and I can feel, while pressing, something slip like intestines. These are not the usual characteristics of a fibroid. In most fibroids there is a definite area of dulness. Yet it is possible for a fibroid to be developed posteriorly and have intestinal adhesions anteriorly, and thus simulate a hæmatoma, but such adhesions are rare.

Now we shall have the feet elevated and make a bimanual examination. As I push my finger into the vagina it comes upon a tumor about an inch behind the subpubic ligament; it is a soft solid tumor with an indefinite feeling of elasticity. Pressing up behind the pubes, I find the cervix high up in front. Bimanually I feel the uterus passing up on the anterior surface of this tumor. It is intimately connected and moves slightly with it.

At a previous digital examination of the rectum the tumor seemed to extend below the level of the viscus. It felt as if it had developed in the connective tissue and become somewhat attached to the rectum, and, as it developed in all directions, that part of the bowel attached was raised up on the side of the burrowing tumor. At the same time the calibre of the rectum was not interfered with, as would be likely from so large a hæmatoma. The tumor is quite definite in shape above, and is reported by her physician, who is my colleague, Dr. Frank Cary, to be growing.

This case illustrates the fact that at different examinations a tumor may feel entirely different, and that the signs and symptoms of various tumors or enlargements may be mixed and render a positive diagnosis impossible. This mass feels like a hæmatoma and occupies the favorite position of one, but lacks the history and some of the physical signs. It occupies a very unusual position for a uterine fibroid and possesses few of the physical signs. In such cases it is always better to examine the patient a second time, and, if practicable, under the influence of ether. As the original diagnosis of fibroid made by Dr. Cary and myself would seem not unlikely to be correct, we shall make an exploratory abdominal incision and be prepared for a hysterectomy.

In performing an operation the first thing to do is to place your instruments where you can reach them yourself. Being ready I take out a few forceps, my knife and probe-pointed scissors, and put them on the towel covering the pubes where they will be handy. I shall not

make this incision very low down, because the bladder is, of course, pulled up with the uterus. I put the point of the knife on the median line and make a deliberate incision downward from a little below the umbilicus towards the pubes, cutting through the fat with one or two strokes. I am now down to the fascia, and we have here quite a little welling of blood from vessels near the bottom. By using cold water we can stop this bleeding, and thus escape the annoyance attending the use of many hæmostatic forceps. I shall now make a little nick in the fascia to see whether I am in the median line. I find by probing that I am in the sheath of the right rectus muscle near the edge. Having located the edge of the muscle with the probe-point of the scissors, I rapidly slit up the fascia with them, and force the muscular edges apart with the knife-handle. Now I take up some of the subperitoneal connective tissue with forceps, and partly cut and partly tear it asunder until we arrive at the denser peritoneal membrane.

Right here I will illustrate another point in diagnosis. Not having cut through the peritoneum, I can palpate this tumor quite freely. I could stop here or go ahead. If I found a hæmatoma I could stop. But, as it gives to the fingers the impression of a fibroid, I shall go ahead. In attempts at palpation through the peritoneal membrane, care must be taken, however, not to separate it extensively from its parietal connections, as subsequent suppuration would probably result.

Lifting up the peritoneum with forceps and cutting through it, I find that the underlying omentum does not sink away from it upon the entrance of air, but clings to it, and is therefore adherent. This accounts for the sensation of something slipping which confused our diagnosis, and rendered the tumor more difficult of palpation than fibroids ordinarily are. Gently separating the delicate structure from the parietes, we at last get a glimpse of the corpus uteri projecting up out of a soft fibroid mass, like a king on a throne. I confess that even a king sits easier on his throne than does the surgeon stand before this mitred mass. Housed under overarching broad ligaments and filling the pelvis, there is nothing to do with it but to tear the mass from its stronghold, trusting that the patient's already exhausted strength will endure the trial. The broad ligaments are flattened over it so that they cannot be ligatured beforehand, and more or less hemorrhage may be expected to occur.

Before making this desperate attack, however, we must take our precautions. As the patient is very fat, we clean away all fatty *débris* from the parietal edges, to keep it out of the abdominal cavity. We

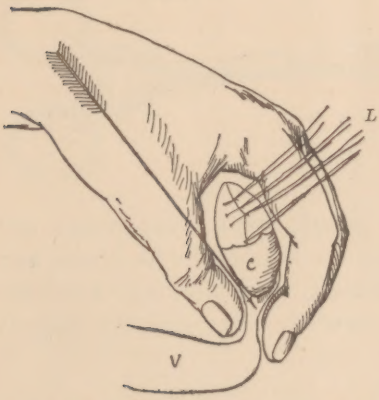
also protect the intestines—for they are our most easily damaged structures—from irritation, by covering them with a large flat sponge, clamped to the peritoneal edges by forceps.

I want now to cut the capsule and enucleate, but this capsule does not separate posteriorly, and the pelvis is so evenly full of tumor that I cannot get at it advantageously. Even though Dr. Watkins is pulling up the fundus with vulsellum forceps, I cannot raise the mass in the least. I therefore rather blindly gouge down behind it with my fingers, tearing through the peritoneum at the posterior reflection, and lift the mass up. One connective-tissue strand may be easily torn, but when thousands of them are interwoven it requires almost stronger fingers than mine. It tires them out and makes them ache. I may truly be said to be making my living by the sweat of my brow. Gradually, however, I get it up from its bed, and now, by the practice of as much delicacy of touch as I have just exhibited of vigor, I hope to be able to successfully ligature the upper parts of the torn broad ligaments at the sides of the pelvis,—still almost inaccessible with the tumor thus in the way.

Having accomplished this, and cut the threads near the knots, I clamp the broad ligaments against the tumor by forceps as best I can. I now make a superficial incision through the peritoneum transversely across the anterior surface of the uterus, about an inch above the attachment of the bladder, and separate the peritoneum and bladder from the uterus down to the vagina. Now I put my rubber tubing around the cervix under the mass, tie it, transfix it with pedicle-pins, and amputate a little above the latter. I cut a transverse wedge-shaped piece out of the stump so as to lessen its size, ligature it in three parts just above the rubber tubing, and sew up the edges with four or five interrupted coarse sutures, leaving all ends about six inches long. I cut the tubing off, and, as there is no bleeding, take out the pins and hold the blanched stump up by the long ends of the sutures. The stump being thus prepared, I take it in my left hand, with my thumb against the anterior wall reaching clear down to the vagina, and my first two fingers behind it in the recto-uterine cul-de-sac. By pushing down and separating the bladder from the vagina for about half an inch from the cervix, I can make my thumb and fingers meet under the external os uteri with only the vaginal walls intervening. (See Fig. 1.) With a slender pair of hæmostatic forceps I punch down between my thumb and the cervix until the forceps-point enters the vagina, where it is felt by Dr. Gaven. By spreading the blades, I can draw up the anterior vaginal wall, and take hold of it about the puncture with other forceps.

By scissor-snips I enlarge the opening laterally and anteriorly, and ligature a spurting arteriole with strong catgut. Now I pass the small forceps holding the stump sutures down through the vaginal opening just made, and, while Dr. Gaven pulls them down into the vagina, I assist by my thumb and fingers in anteverting the stump. It slides into place in the vagina like a foot in a boot, and the peritoneal cavity is rid of it.

Fig. 1.



Method of Holding Stump when Puncturing the Anterior Vaginal Wall with Slender Forceps.—*V*, vagina; *C*, cervix; *L*, ligatures. The arrow represents the direction of introduction of the forceps.

While Dr. Watkins holds back the intestine, I take this long catgut thread, pierce the peritoneum coming from the bladder at the left side, and attach it to the peritoneum posteriorly so that it draws the serous membrane together at the edge of the left broad ligament stump. Two or three more punctures of the needle, with care not to pierce too deeply, bring me with my continuous suture to the right broad ligament stump. Now the uterine pedicle is entirely shut off from the peritoneal cavity, and can do no harm. There is a little bloody oozing in the pelvis, owing to the extensive enucleation, but it is much less than there would have been had we not sewed up the peritoneal edges. Those of you who can see well, however, have noticed that I was unable, as in most cases, to place the catgut continuous suture so as to cover all of the raw surface. Hence, in closing up, I shall leave this glass drainage-tube, which I put in so as to reach to the bottom of the pelvis. In about thirty-six hours, when the bloody oozing will have become serous in character, I shall remove it.

Now there is little doubt that this patient will get well. You may ask me why I feel so confident of her recovery, since this is one of the roughest and most difficult intraperitoneal operations imaginable. I answer, simply because there is nothing left in the cavity to kill her. It is not what you take out, but what you leave, that kills the patient, as Dr. Parkes used to say. There are no bruised viscera left, only a narrow catgut suture a trifle over an inch long with a tiny broad ligament stump at each end, and a little raw connective tissue, all at the bottom of the pelvis.

The external stiches being in, and the rim of the drainage-tube protected by a rubber dam, we have now but to draw the patient to the end of the table, put her in the lithotomy position, introduce our vaginal retractors, and slip this clamp (Fig. 2), as you see, along the stump sutures, over the anteverted stump, and clamp it. It reaches just beyond the ligatures, so as to include them. The stump will slough off at this point, and the slough be inclosed in its blades and kept from contact with the living tissues. (See Fig. 3.) After the separation of the slough, which will occur in two weeks, the remaining cervix will right itself and the granulating tissue contract, so that in a short time the portio vaginalis will present a normal feel to the examining finger.

FIG. 2.

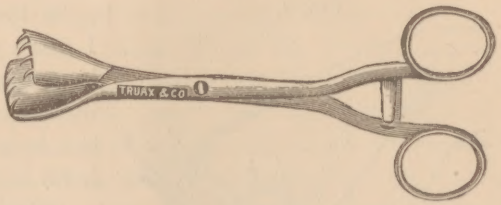
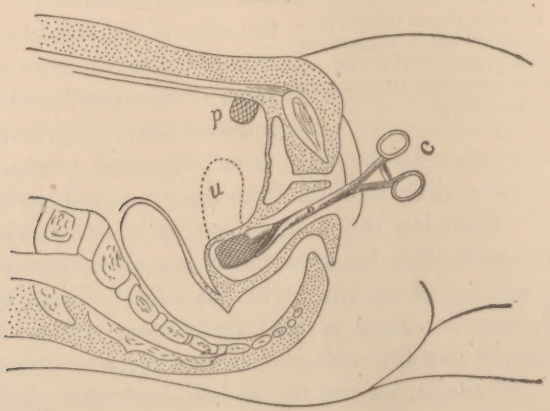


FIG. 3.



c, clamp forceps applied; *p*, position of stump in ventral fixation; *u*, normal position of uterus.

[*Later Note.*—The patient made a good recovery.]